

NOTICE OF INDEPENDENT REVIEW DECISION

July 10, 2003

MDR Tracking #: M2-03-1302-01

IRO Certificate #: IRO 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained an injury to his lower back on ___ secondary to a slip and fall at work. He saw a physician and eventually started a physical therapy regimen. The patient had a lumbar MRI performed on 01/10/02 which revealed a disc herniation at L5-S1 with annular tear and a disc protrusion at L4-5 with mild thecal sac indentation. He underwent three lumbar epidural steroid injections with very minimal pain relief. Discography performed on 06/13/02 showed abnormalities at L4-5 and L5-S. He had a lumbar laminectomy on 07/22/02. He was prescribed a TENS unit a few months post-operatively to help with pain.

Requested Service(s)

Purchase of an R54i sequential 4-channel combination interferential and muscle stimulator unit

Decision

It is determined that the proposed purchase of an R54i sequential 4-channel combination interferential and muscle stimulator unit is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

There is no significant benefit that can be expected from the use of an R54i sequential 4-channel interferential muscle stimulator unit in a case such as this. There is no documented efficacy for this type of muscle stimulator in the management of chronic low back pain. Therefore, it is determined that the proposed purchase of an R54i sequential 4-channel combination interferential and muscle stimulator unit is not medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,